

EXHIBIT B

New York City Comptroller
Scott M. StringerOffice of the New York City Comptroller
1 Centre Street
New York, NY 10007

Form Version: NYC-COMPT-BLA-PI1-D

Personal Injury Claim Form

Electronically filed claims must be filed at the NYC Comptroller's Website. If your claim is not resolved within 1 year and 90 days from the date of occurrence you must start legal action to preserve your rights.

I am filing: ☐ On behalf of myself.☐ On behalf of someone else. If on someone else's behalf, please provide the following information.

Last Name:

First Name:

Relationship to
the claimant:**Claimant Information**

*Last Name:

Terr

*First Name:

Chris

*Address:

MDC

Address 2:

*City:

New York

*State:

NEW YORK

*Zip Code:

10013

*Country:

USA

Date of Birth:

Format: MM/DD/YYYY

Soc. Sec. #

HICN:

(Medicare #)

Date of Death:

Format: MM/DD/YYYY

Phone:

*Email Address: mwalle1@gmail.com

*Retype Email

Address:

mwalle1@gmail.com

Occupation:

City Employee?

☐ Yes ☒ No ☐ NA

Gender

☒ Male ☐ Female ☐ Other☒ Attorney is filing.**Attorney Information (If claimant is represented by attorney)**

Firm or Last Name:

Law Office of Matthew B. Waller

Firm or First Name:

Address:

20 Vesey Street

Address 2:

Suite 503

City:

New York

State:

NEW YORK

Zip Code:

10007

Tax ID:

Phone #:

(212) 766-4404

*Email Address:

mwalle1@gmail.com

*Retype Email

Address:

mwalle1@gmail.com

The time and place where the claim arose

*Date of Incident:

11/13/2019

Format: MM/DD/YYYY

Time of Incident:

Format: HH:MM AM/PM

*Location of

Incident:

MDC, 9 north

Address:

Address 2:

City:

*State:

NEW YORK

Borough:

MANHATTAN (NEW YORK)

*** Denotes required fields. A Claimant OR an Attorney Email Address is required.**



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***Manner in which
claim arose:**

On November 13, 2019, the Claimant Chris Terr - B&C# 141-19-02613 was injured as a result of the negligence of the City of New York (CITY) and New York City Department of Correction (DOC) when he was caused to slip and fall and sustain serious injuries. On the aforementioned date and location as claimant was lawfully within the bathroom area claimant was caused to slip and fall as a result of wet ground. This Hazard/wet surface was left without warning and/or repair causing claimant to fall to the ground and sustain injuries. Such condition which constituted a hazardous and/or dangerous condition caused him to fall down. At no time did the Correction Staff put up signs making lawful users of the premises aware that the floor was wet/dangerous/defective or that a hazard was present and allowed the condition to remain for an unreasonable amount of time. As a result of the fall claimant sustained serious injuries including but not limited to injury to his head, neck, back, amongst other parts of his body. Notice both actual and constructive are claimed as either the City and/or the DOC created this condition and/or allowed this condition to exist for an unreasonable amount of time. A claim is made for negligence against the City and the DOC as the injuries occurred while the claimant was in their care, custody and control.



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**The items of
damage or injuries
claimed are
(include dollar
amounts):**

For the serious injuries sustained by the claimant, including but not limited to his head, neck, back, amongst other parts of his body, a claim is made for one million (\$1,000,000.00) dollars.



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Medical Information

1st Treatment Date:	<input type="text"/>	Format: MM/DD/YYYY
Hospital/Name:	<input type="text"/>	
Address:	<input type="text"/>	
Address 2:	<input type="text"/>	
City:	<input type="text"/>	
State:	<input type="text"/>	
Zip Code:	<input type="text"/>	<input type="text"/>
Date Treated in Emergency Room:	<input type="text"/>	Format: MM/DD/YYYY
Was claimant taken to hospital by an ambulance?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA	

Employment Information (If claiming lost wages)

Employer's Name:	<input type="text"/>	
Address	<input type="text"/>	
Address 2:	<input type="text"/>	
City:	<input type="text"/>	
State:	<input type="text"/>	
Zip Code:	<input type="text"/>	<input type="text"/>
Work Days Lost:	<input type="text"/>	
Amount Earned Weekly:	<input type="text"/>	

Treating Physician Information

Last Name:	<input type="text"/>	
First Name:	<input type="text"/>	
Address:	<input type="text"/>	
Address 2:	<input type="text"/>	
City:	<input type="text"/>	
State:	<input type="text"/>	
Zip Code:	<input type="text"/>	<input type="text"/>

Witness 1 Information

Last Name:	<input type="text"/>	
First Name:	<input type="text"/>	
Address	<input type="text"/>	
Address 2:	<input type="text"/>	
City:	<input type="text"/>	
State:	<input type="text"/>	
Zip Code:	<input type="text"/>	Phone: <input type="text"/>

Witness 2 Information

Last Name:	<input type="text"/>	
First Name:	<input type="text"/>	
Address	<input type="text"/>	
Address 2:	<input type="text"/>	
City:	<input type="text"/>	
State:	<input type="text"/>	
Zip Code:	<input type="text"/>	Phone: <input type="text"/>

Witness 3 Information

Last Name:	<input type="text"/>	
First Name:	<input type="text"/>	
Address	<input type="text"/>	
Address 2:	<input type="text"/>	
City:	<input type="text"/>	
State:	<input type="text"/>	
Zip Code:	<input type="text"/>	Phone: <input type="text"/>

Witness 4 Information

Last Name:	<input type="text"/>	
First Name:	<input type="text"/>	
Address	<input type="text"/>	
Address 2:	<input type="text"/>	
City:	<input type="text"/>	
State:	<input type="text"/>	
Zip Code:	<input type="text"/>	Phone: <input type="text"/>



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Complete if claim involves a NYC vehicle**Owner of vehicle claimant was traveling in**

Last Name:

First Name:

Address

Address 2:

City:

State:

Zip Code:

Non-City vehicle driver

Last Name:

First Name:

Address

Address 2:

City:

State:

Zip Code:

Insurance InformationInsurance Company
Name:

Address

Address 2:

City:

State:

Zip Code:

Policy #:

Phone #:

Non-City vehicle informationMake, Model, Year
of Vehicle:

Plate #:

VIN #:

City vehicle information

Plate #:

City Driver Last
Name:City Driver First
Name:**Description of
claimant:**

- ☐ Driver ☐ Passenger
☐ Pedestrian ☐ Bicyclist
☐ Motorcyclist ☐ Other

**Total Amount
Claimed:**

\$1,000,000.00

Format: Do not include "\$" or ",".

The **Total Amount Claimed** can only be entered once the following
required fields are entered:

Claimant Last Name

Claimant First Name

Claimant Address, City, State, Zip Code, and Country

Claimant Email or Attorney Email

Date of Incident

Location of Incident (including State)

Manner in which claim arose

I certify that all information contained in this notice is true and correct to the best of my knowledge and belief. I understand that the willful
making of any false statement of material fact herein will subject me to criminal penalties and civil liabilities.